H CARE FINANCING ADMINISTRATION "Substitute per letter dated 10/28/02" OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-12

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: June 4, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: CFR 42

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $~~108,622~~ 40,324
b. FFY 03 $~~135,094~~ 82,718

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attchment 4.19A pages 3, 4, 4a, 9b, 10, 10a, 16a, 16b, and 16c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attchment 4.19A pages 3, 4, 10, 10a, 16a, and 16b

10. SUBJECT OF AMENDMENT: Allows for the following:
critical access hospitals to request a rate adjustment;
the FRA assessment not included in cost reports ending prior to January 1, 2001
increased cost from out-of-state Medicaid days in total projected XIX days; and
a Missouri specific trend.

GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: D. K. Martin

16. RETURN TO:

13. TYPED NAME: Dana Katherine Martin

14. TITLE: Director

15. DATE SUBMITTED: 6/26/02

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/27/02

18. DATE APPROVED: 8/28/02

PLAN APPROVED ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 6/4/02

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME:

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

*Substitute per letter dated 10/23/02 m

INSTRUCTIONS FOR COMPLETING FORM HCFA-179

Use Form HCFA-179 to transmit State plan material to the regional office for approval. A separate typed transmittal form should be completed for each plan/amendment submitted.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a calendar year basis (e.g., 92-001, 92-002, etc.).

Block 2 - State - Type the name of the State submitting the plan material.

Block 3 - Program Identification - **Title XIX of the Social Security Act (Medicaid)**

Block 4 - Proposed Effective Date - Enter the proposed effective date of material.

Block 5 - Type of Plan Material - Check the appropriate box.

Block 6 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 7 - Federal Budget Impact- 7(a) - Enter 1st **Federal Fiscal Year (FFY) impacted by the SPA & estimated Federal share of the cost** of the SPA (in thousands) for 1st FFY. 7(b) - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. See SMM section 13026.

Block 8 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material transmitted. If additional space needed, use bond paper.

Block 9 - Page No.(s) of the Superseded Plan Section or Attachment (if applicable) - Enter the page number(s) (including the transmittal sheet number) that is being superseded. If additional space needed, use bond paper.

Block 10 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 11 - Governor's Review - Check the appropriate box. See SMM section 13026 B.

Block 12 - Signature of State Agency Official - Authorized State official signs this block.

Block 13 - Typed Name - Type name of State official who signed block 12.

Block 14 - Title - Type title of State official who signed block 12.

Block 15 - Date Submitted - Enter the date you mail plan material to RO.

Block 16 - Return To - Type the name and address of State official this form should be returned to.

Block 17-23 (FOR REGIONAL OFFICE USE ONLY)

Block 17 - Date Received - Enter the date plan material is received in RO. See ROM section 6003.2.

Block 18 - Date Approved - Enter the date RO approved the plan material.

Block 19 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 23 or attach a sheet.

Block 20 - Signature of Regional Official - Approving RO official signs this block.

Block 21- Typed Name - Type approving official's name.

Block 22 - Title - Type approving official's title.

Block 23 - Remarks - Use this block to reference pen and ink changes, a partial approval, more than one effective date, etc. If additional space needed, use bond paper.

Any changes to the desk reviewed cost report after the Division issues a final decision on assessment or payments based on the base cost report will not be included in the calculations.

D. Charity Care - results from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

E. Contractual allowances–Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

F. Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

G. Critical Access. Hospitals which meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act. A Missouri expanded definition of critical access shall also include hospitals which meet the federal definitions of both a rural referral center and sole community provider and is adjacent to at least one county that has a Medicaid eligible population of at least thirty percent (30%) of the total population of the county or hospitals which are the sole community hospital located in a county that has a Medicaid population of at least thirty percent (30%) of the total population of the county.

H. Disproportionate Share Reimbursement. The disproportionate share payments described in sections XVI and XVII.B include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection V.A.1 and 2 and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation are described in sections XVI, and XVII.B., of this regulation. These Safety Net and Uninsured Payments Add-Ons are subject to federal limitation as described in the Omnibus Reconciliation Act of 1993 (OBRA 93) and subsection VI.E.

I. Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification of the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

J. Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part 405) as determined by the servicing fiscal intermediary based on yearly Hospital Cost Reports.

K. Non-reimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services or costs and services specifically excluded or restricted in this plan or the Medicaid hospital provider manual.

L. Per Diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section III.

M. Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's Medicaid per-diem cost per day as determined in accordance with the general plan rate calculation from section III of this regulation using the base year cost report (by dividing allowable Medicaid inpatient costs by total Medicaid inpatient days, including nursery days).

N. Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

O. Children's hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) and which has designated in its licensor application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit as defined in 19 CSR 30-20.021(4)(F).

P. FRA. The Federal Reimbursement Allowance shall be an allowable cost.

Q. Hospital-sponsored primary care clinic–A clinic location which has met all of the following criteria:

1. The clinic shall not be physically located within a licensed hospital;

2. The clinic must be enrolled as a Medicaid provider;

3. The clinic is not certified by the Division of Health Standards and Quality, Health Care Financing Administration (HSQ/HCF) as being part of any hospital; and

4. The sponsoring hospital has completed and returned Hospital-Sponsored Primary Care Clinic Application to the Missouri Division of Medical Services by May 1, 1994, providing verification of the following:

   A. The sponsoring hospital and the clinic are subject to the bylaws and operating decisions of the same governing body; or

   B. The sponsoring hospital contributes at least five hundred thousand dollars ($500,000) annually towards the operation of the clinic.

any change in its Medicaid inpatient allowable costs due to the change in its property taxes. The Medicaid share of the change in property taxes will be calculated for the State Fiscal Year in which the change is reported by multiplying the increase or decrease in property taxes applicable to the current State Fiscal Year by the ratio of allowable Medicaid inpatient hospital costs to total costs of the facility. (For example, if the property taxes are assessed starting January 1 for the calendar year, then one half of the calendar year property taxes will be used to calculate the additional inpatient direct Medicaid payments for the period of January 1 to June 30.

F. Rate Reconsideration

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in subsection III.A.. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division of Medical Services' final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the Medicaid Agency:

   (a) Substantial changes in or costs due to case mix;

   (b) New, expanded or terminated services as detailed in subsection V.C.

   (c) When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance; and

   (d) Per diem rate adjustments for critical access and trauma center hospitals.

      (1) Critical access hospitals meeting either the federal definition or the Missouri expanded definition may request per diem rate adjustments in accordance with this subsection. The per diem rate increase will result in a corresponding reduction in the Medicaid Direct payment.

         a. Hospitals which meet the federal definition as a critical access hospital may request a per diem rate equal to one hundred percent (100%) of their estimated Medicaid cost per day as determined in Section (XV).

b. Hospitals which meet the Missouri expanded definition as a critical access hospital may request a per diem rate equal to seventy-five percent (75%) of their estimated Medicaid cost per day as determined in Section (XV).

3. The following will not be subject to review under these procedures:

(a) The use of Medicare standards and reimbursement principles;

(b) The method for determining the trend factor;

(c) The use of all-inclusive prospective reimbursement rates; and

(d) Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program.

4. As a condition of review the Missouri Division of Medical Services may require the hospital to submit to a comprehensive operational review. Such review will be made at the discretion of the State Medicaid Agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the Agency's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not respond within the sixty (60)-day period, the request shall be deemed denied.

G. Sanctions

Sanctions may be imposed against a provider in accordance with applicable state and federal regulations.

VI. Disproportionate Share

A. Inpatient hospital providers may qualify as a Disproportionate Share Hospital based on the following criteria. Hospitals shall qualify as Disproportionate Share Hospitals for a period of only one (1) state fiscal year and must re-qualify at the beginning of each state fiscal year to continue their disproportionate share classification.

1. If the facility offered non-emergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a Metropolitan Statistical Area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer non-emergency obstetric services as of December 21, 1987;

XV. Direct Medicaid Payments.

A. Direct Medicaid payments. Direct Medicaid payments will be made to hospitals for the following allowable Medicaid costs not included in the per diem rate as calculated in section III.

1. The increased Medicaid costs resulting from the FRA Assessment not included in the cost report ending prior to January 1, 2001;

2. The unreimbursed Medicaid costs applicable to the trend factor which is not included in the per diem rate;

3. The unreimbursed Medicaid costs for capital and medical education not included in the trended per diem cost as a result of the application of the sixty percent (60%) minimum utilization adjustment in paragraph III.A.4.;

4. The increased cost per day resulting from the utilization adjustment. The increase cost per day results from lower utilization of inpatient hospital services by Medicaid recipients now covered by a MC+ health plan;

5. The poison control adjustment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a Medicaid managed care region; and

6. The Direct Medicaid Payment for Missouri Medicaid services will be increased by the estimated ratio of total Medicaid recipients including out-of-state percentage to Medicaid in-state only recipients.

B. Direct Medicaid Payment will be computed as follows:

1. The Medicaid share of the FRA Assessment will be calculated by dividing the hospitals Medicaid patient days by total hospita'ls patient days to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the FRA assessment for the current SFY to arrive at the increased allowable Medicaid costs;

2. The unreimbursed Medicaid costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated Medicaid patient days for the current SFY.

(a) The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph III.B.1., using the rate calculation in subsection III.A. In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of Medicaid residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospitals base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

(b) For hospitals that meet the requirements in paragraphs VI.A.1., VI.A.2. and VI.A.4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year, based on the determination of the Division of Medical Services exercising its sole discretion as to which report is most representative of costs incurred. For hospitals that meet the requirements in paragraphs VI.A.1., and VI.A.3., of this rule (first tier Disproportionate Share Hospitals), the base year operating costs shall be based on the third prior year cost report. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve-month cost report and a partial year cost report, its base period cost report for that year will be the twelve-month cost report.

(c) The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment and the poison control costs computed in paragraphs XV.B.1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph V.C.4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated Medicaid patient days for the SFY;

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4. The utilization adjustment cost is determined by estimating the number of Medicaid inpatient days the hospital will not provide as a result of the MC+ Health Plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated Medicaid days for the current SFY to arrive at the Medicaid utilization adjustment;

5. The poison control cost shall reimburse the hospital for the prorated Medicaid managed care cost. It will be calculated by multiplying the estimated Medicaid share of the poison control costs by the percentage of MC+ recipients to total Medicaid recipients; and